MEDICAL ASSISTANCE ELIGIBILITY OVERVIEW

Department of Social and Health Services
Medical Assistance Administration

October 2002

***NOTE**: These are guidelines only. The Department of Social and Health Services (DSHS) has responsibility for making eligibility decisions for medical benefits.*

DSHS 22-315(X) 4/01

Washington State
Department of Social
& Health Services

TABLE OF CONTENTS

This information is also available on the MAA website http://MAA.dshs.wa.gov and click on Eligibility for Medical Programs.

NOTE: These are guidelines only. The Department of Social & Health Services (DSHS) has responsibility for making eligibility decisions for medical benefits.

To obtain this publication in alternative format, please contact the Department of Social & Health Services ADA Coordinator.

INTRODUCTION & DEFINITIONS

This guide offers an overview of eligibility requirements for medical programs. It does not include all requirements or consider all situations that may arise. Please contact your local Community Services (CSO) or Home and Community Services (HCS) office for information about a specific situation.

Income levels based on Federal Poverty Level (FPL) and Cost of Living Adjustments changes yearly. This booklet is updated regularly to reflect those changes.

MEDICAID: the state and federally funded aid program that covers the Categorically Needy (CN) and Medically Needy (MN) programs.

CATEGORICALLY NEEDY (CN): the federally matched Medicaid programs that provide the broadest scope of medical coverage. Persons may be eligible for CN only, or may also be eligible for cash benefits under the SSI (Supplemental Security Income) or TANF (Temporary Assistance for Needy Families) programs. CN includes full scope of coverage for pregnant women and children.

FEE-FOR-SERVICE: the term used when a client is able to go to any medical provider who will accept the MAA medical coupon called a Medical Assistance Identification card.

HEALTHY OPTIONS: the name of the Washington State, Medical Assistance Administration's managed care program.

MANAGED CARE: a prepaid comprehensive system of medical and health care delivery provided through a designated health care plan which is contracted with MAA.

MEDICALLY NEEDY (MN): a federal and state funded Medicaid Program for aged, blind, or disabled persons, as well as pregnant women, children and refugees with income and/or resources above CN limits. It provides slightly less medical coverage than CN.

TANF: the Temporary Assistance for Needy Families program offering cash and other benefits to families in need.

WORKFIRST: Washington State's Welfare to Work program for federal TANF legislation replacing the former AFDC program.

FAMILY MEDICAL

TANF (TEMPORARY ASSISTANCE FOR NEEDY FAMILIES) and FAMILY MEDICAL PROGRAM: This program provides aid to children and adult(s) who care for them. Families with dependent children under the age of 19, whose income and resources are below TANF limits may receive both TANF cash benefits and CN medical. TANF cash benefits are restricted to 60 months maximum in a lifetime, but there is no time limit for receiving medical. **A family may choose to only receive CN medical to save TANF eligibility months.**

INCOME LIMITS – FAMILIES WITH DEPENDENT CHILDREN

NUMBER OF PERSONS	CN INCOME LIMIT
1	$349
2	$440
3	$546
4	$642
5	$740
6	$841

In determining net income, we deduct 50% of the family's earnings, actual child care costs, and child support paid out by the family.

RESOURCES: For medical eligibility, a family may have $1,000 in resources at the time of application. Once a family is eligible, there is no resource test for families who receive only medical.

MEDICAL EXTENTION BENEFITS (MEB): Families are eligible for up to 12 months of extended CN medical benefits when earned income increases above program standards. These benefits are sometimes called Transitional Medical Assistance (TMA). Beginning in 2002, a premium will be charged to all non-pregnant adults during the second six months of MEB, if the family's countable income is over 100% of the FPL. American Indian/Alaska Natives are exempt from the payment of premiums.

Families are eligible for up to 4 months of extended CN medical benefits when their cash benefits have been terminated because of increased child support.

SPECIAL SITUATIONS: Clients who are **not** eligible for cash benefits **but are eligible** for medical coverage include:

- Persons who are not cooperating with WorkFirst activities;
- Teen parents who are not in an approved living situation or are not meeting school requirements;
- Persons who have reached the 60-month TANF cash benefit limit;
- Other behavioral restrictions.

STATE FAMILY ASSISTANCE (SFA): SFA is the state-funded cash and medical program for legal immigrant families who do not meet the eligibility requirements for the federal programs due to citizenship or immigration status. The program provides the same scope of medical coverage as Family Medical above. **Effective October, 2002 this program will no longer provider medical coverage. Families on SFA will be encouraged to apply for Basic Health (BH). See back page for BH phone number and web site.**

WOMEN'S HEALTH

The CN medical program for low-income pregnant women has no resource limits and the income limits are based on 185 percent of the Federal Poverty Level (FPL).* The pregnant woman can be eligible at any time during her pregnancy. Once eligible, the woman continues to be eligible throughout the pregnancy and postpartum period regardless of changes in income and household composition.

To determine the pregnant woman's family size, count the pregnant woman and add one for each verified unborn.

EXAMPLE: A woman who verifies she is pregnant with twins is considered to be a three-person family.

Effective April 1, 2002:

NUMBER OF PERSONS	INCOME LIMIT – 185% FPL
1	NA
2	$1,841
3	$2,316
4	$2,791
5	$3,266
6	$3,741
Add $475 for each additional household member	

*Pregnant women with income above 185 percent FPL may be eligible for the MN program.

POSTPARTUM EXTENSION: The postpartum extension provides full scope medical coverage for women who receive medical benefits at the time their pregnancy ends. These funds provide continued medical coverage for 60 days after the month in which pregnancy ends (e.g., pregnancy ends June 10, medical benefits continue through August 31). Women receive this extension regardless of how the pregnancy ends.

FAMILY PLANNING EXTENSION: The family planning extension provides an additional 10 months of medical coverage for **family planning services only**. The extension follows the 60 day postpartum coverage for women who received medical benefits for the pregnancy. Women receive this extension regardless of how the pregnancy ends.

CASH ASSISTANCE FOR PREGNANT WOMAN: TANF cash benefits are available to pregnant women. Eligible women receive full scope medical coverage under (CN) Categorically Needy.

NONCITIZEN PREGNANT WOMAN: A pregnant woman is eligible for the CN scope of care under the state-funded pregnant woman program if she is not eligible for Medicaid due to citizenship or immigration status, including undocumented women.

BREAST AND CERVICAL CANCER Treatment Coverage: This program began July 2001 and provides medical coverage for women who have been diagnosed with breast or cervical cancer or a related pre-cancerous condition. To be eligible, a woman must be identified as needing treatment through the Department of Health's (DOH) Breast and Cervical Health Program (BCHP) or by Breast and Cervical Early Detection program funded by the Centers for Disease Control. Income and resources eligibility is established by the DOH screening program.

An uninsured woman is eligible if she:

- Is under age 65;
- Has been screened by the BCHP and the CDC-funded program; and
- Requires treatment for breast or cervical cancer; and
- Does not have other insurance.

For more information see the Department of Health Web site at http://www.doh.wa.gov/wbchp/default.htm.

TAKE CHARGE: A new Family Planning program began in July 2001. The program covers pre-pregnancy family planning services, helping participants take charge of their lives before an unintended pregnancy occurs.

Both women and men may be eligible if:

- Their family income is at or below 200 percent of FPL;
- They do not have health insurance coverage; or
- Their current health insurance coverage does not include comprehensive family planning benefits.

Effective April 1, 2002:

NUMBER OF PERSONS	INCOME LIMIT – 200% FPL
1	$1,477
2	$1,990
3	$2,504
4	$3,017
Add $514 for each additional household member	

TAKE CHARGE covers:

- Annual examination;
- Family planning education and risk reduction counseling;
- FDA-approved contraceptive methods including: birth control pills, IUDs and emergency contraception;
- Over the counter contraceptive products such as; condoms and contraceptive creams or foams; and
- Sterilization procedures.

Services are accessed through local clinics, doctor's offices and pharmacies who are participating in *TAKE CHARGE*. For a list of providers by area call the toll-free Family Planning Hot Line at 1-800-770-4334. Additional information can be found on the DSHS Web site at http://maa.dshs.wa.gov/familyplan.

CHILDREN'S MEDICAL

The CN medical program for children has two categories.

NEWBORNS: Newborns are automatically eligible for CN coverage for 12 months if their mother received medical benefits at the time of the child's birth. There are no income or resource limits.

CHILDREN UNDER AGE 19: This CN program has no resource limits and the income limits are based on 200 percent of the Federal Poverty Level (FPL). Living with a parent/guardian is not a requirement for eligibility in this program. Children remain eligible for 12 months regardless of changes of circumstances.

Effective April 1, 2002:

NUMBER OF PERSONS	INCOME LIMIT – 200% FPL
1	$1,477
2	$1,990
3	$2,504
4	$3,017
5	$3,530
6	$4,044
Add $514 for each additional household member	

In determining the net income, the family can deduct a $90 earned income disregard for each working parent, the actual child care costs, and child support paid out by the family.

MEDICAL COVERAGE FOR IMMIGRANT CHILDREN: Some immigrant children who entered the United States after August 22, 1996, may not be eligible for Medicaid due to immigration status, but are eligible for the state-funded medical program up to 200% of FPL listed above. The scope of care is the same as for CN medical. **As of October, 2002 this program will no longer be offered. Clients are encouraged to apply for Basic Health (BH). See last page for BH phone number and website.**

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP): CHIP is a federal/state program that covers children under age 19 in families whose income is too high for Medicaid, but below 250% FPL. To be eligible for CHIP a child:

1. Cannot be eligible for Medicaid;
2. Cannot be covered by other creditable insurance; and

3. Must pay monthly premiums to the department.

CHIP has the same scope of coverage as the Categorically Needy program (CN). CHIP is not the same as the Children's Health program, (see below) which is a state–funded program for non-citizen children.

Effective April 1, 2002:

NUMBER OF PERSONS	INCOME LIMIT – 200%-250% FPL
1	$1,846
2	$2,488
3	$3,130
4	$3,771
5	$4,413
6	$5,055
Add $642 for each additional household member	

Children with income above 250% of FPL may be eligible for the MN program.

CHILDREN'S HEALTH PROGRAM: The Children's Health Program is the state-funded program for children under age 18 who are not eligible for Medicaid because they are not citizens, i.e. undocumented. This program has no resource limit and its income limit is based on 100 percent of the Federal Poverty Level (FPL). Medical coverage is the same as for CN (Categorically Needy). Living with a relative and citizenship are not eligibility requirements for the Children's Health Program. **As of October, 2002 this program will no longer be offered. Clients are encouraged to apply for Basic Health (BH). See last page for BH phone number and web site.**

Effective April 1, 2002:

NUMBER OF PERSONS	INCOME LIMIT – 100% FPL
1	$739
2	$995
3	$1,252
4	$1,509
5	$1,765
6	$2,022
Add $257 for each additional household member	

REFUGEES AND ALIENS

REFUGEES: Under the 100 percent federally-funded Refugee Program, a person who has been granted asylum in the U.S. as a refugee or asylee may receive cash benefits for a maximum of eight months. These persons automatically receive Categorically Needy (CN) medical services. Immediately after entering the U.S., families and single refugees are eligible for this program.

Refugees/asylees who have been in the United States for more than eight months are determined eligible for medical benefits the same as U.S. citizens.

Refugees/asylees who have income above cash grant limits may be eligible for the Medically Needy (MN) program for a maximum of eight months, as described above, when they spend down excess income.

ALIEN EMERGENCY MEDICAL (AEM): Is a federally-funded program for non-citizen aliens with emergent medical conditions. The person must be categorically related to a Medicaid program (e.g., a parent with a dependent child, a disabled adult or a child under age 19), but are ineligible for Medicaid due to citizenship or alien status. Persons eligible for AEM can receive medical benefits for the emergent condition only. Income and resource limits are the same as for the program to which they are related, i.e., CN or MN.

Alien adults, not categorically related to a Medicaid program, may be eligible for Medically Indigent (MI), if they meet MI program requirements, including an emergency medical condition requiring hospital services.

AGED, BLIND, AND DISABLED

SSI – RELATED MEDICAL COVERAGE

Aged, blind, or disabled persons with income and resources below federal Supplemental Security Income (SSI) limits may receive both SSI cash benefits and Categorically Needy (CN) medical, or they may receive CN medical only. The federal Social Security Administration (SSA) administers the SSI program.

Income and resource standards are the same for CN medical only as for SSI cash benefits. Persons with income and/or resources above SSI limits may be eligible for the Medically Needy.

- The SSI income standard is the Federal Benefit Rate (FBR). The Categorically Needy Income Level (CNIL) will be used to determine income eligibility for those who do not receive SSI but whose income is less than the MNIL.

Income standards in the table below are the CNIL.

Effective January 1, 2002:

NUMBER OF PERSONS	ABD RESOURCE LIMIT	ABD INCOME LIMIT AREA 1	ABD INCOME LIMIT AREA 2
1	$2,000	$570.90	$550.45
2	$3,000	$836.90	$817.00

Persons who receive federal cash benefits under the Supplemental Security Income Program (SSI) also receive CN medical coverage automatically.

Healthcare for Workers with Disabilities

Healthcare for Workers with Disabilities (HWD) is a CN medical program that recognizes the employment potential of people with disabilities. Under *HWD*, people with disabilities (age 16 through 64) can earn more money and purchase healthcare coverage for an amount based on a sliding income scale.

HWD has no asset test and the income limits are based on 220 percent of the Federal Poverty Level (FPL).

Effective April 1, 2002:

NUMBER OF PERSONS	INCOME LIMIT – 220% FPL

1	$1,625
2	$2,189

To be eligible, a person must meet federal disability requirements, be employed (including self-employment) full or part time and pay a monthly premium based on the following formula.

Cost of enrollment:

To receive *HWD* benefits, enrollees pay a monthly premium that is based on a sliding income scale. The premium amount cannot be more than 7.5% of total income - but it can be less.

Note: American Indians and Alaska Natives are exempt from paying premiums for HWD.

LONG–TERM CARE (LTC)

LONG-TERM CARE (LTC): LTC services are federally matched programs that fit individual needs and situations. Home and Community-Based services enable some people to continue living in their homes with assistance to meet their physical, medical, and social needs. When these needs cannot be met at home, nursing facility care is available.

Income limits for LTC programs vary depending on the services needed, living situation, and marital status. Some income may be allocated to a spouse and any dependents in the home. The client living at home keeps some income for home maintenance and personal needs. If the client is living in a residential setting, such as an adult family home, adult residential care, or assisted living facility (ALF), the amount of income kept depends upon the particular services received. The client who is living in a nursing facility (NF), keeps a small personal needs allowance **(PNA)** for clothing and incidental expenses. All remaining income is paid toward the cost of care; this is called **"participation."**

Resource limits also vary depending on marital status and other factors. All resources of both spouses are considered together. Certain resources are "excluded," such as the home, household goods and personal effects, a car, and life insurance with a face value not more than $1,500. Most burial plots and prepaid, revocable burial plans not exceeding $1,500, or irrevocable burial plans are also excluded and not counted toward the resource limits.

A Community Spouse (CS) is allowed to keep resources according to the spousal impoverishment legislation. The **Institutional Spouse** (IS) is allowed to keep the same resources indicated in the table on the following page for Aged, Blind and Disabled.

A different income standard is used to determine eligibility for categorically needy (CN) or medically needy (MN) coverage for LTC services. The standard is 300 percent of the Federal Benefit Rate (FBR) and is called the **Special Income Level (SIL).** If gross income is at or below the SIL, CN eligibility for either NF or Home and Community-Based (HCB) services, such as Community Options Program Entry System (COPES) may be approved. If income is above the SIL, MN eligibility may be approved with a spenddown only for NF services. Different rules are used when determining eligibility and participation when both spouses receive LTC services. The local Home and Community Services worker can provide this information as needed.

Effective April 1, 2002:

INSTITUTIONAL STANDARDS	INCOME LIMIT
Medicaid SIL	$1,635
PNA NF/hospital	$41.62
PNA state veterans home	$160
PNA single veteran	$90
COPES maintenance w/o community spouse	$739
COPES maintenance with community spouse	$571

COPES maintenance in ALF	$571
Housing maximum	$739
Community Spouse Maintenance	$2,232
Community spouse income allocation	$1,493
Community spouse excess shelter allowance	$448
Family allocation	$1,493
Utility standard Effective 10-1-02	$275
Spousal resource maximum	$89,280
Statewide private nursing home rate Effective 10-1-02	$4,938

MEDICARE SAVINGS PROGRAMS

Under Medicare's five different cost sharing programs, DSHS may pay the Medicare premiums for certain aged, blind, and disabled clients. These programs have higher income and resource limits.

QUALIFIED MEDICARE BENEFICIARY (QMB): The client must be entitled to Medicare Part A. Income limits are based on 100 percent of the Federal Poverty Level (FPL). Under QMB, DSHS pays for Medicare Part B premiums, deductibles, copayments, and any Medicare Part C, that covers HMO premiums, and copays.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB): The client must have applied for or be enrolled in Medicare Part A. Income limits are over 100 percent of the Federal Poverty Level (FPL) but under 120 percent of the FPL. Under SLMB, DSHS pays the client's Medicare Part B premium **only**.

QUALIFIED Individual (QI-1) (formerly ESLMB**):** The client must have applied for or be enrolled in Medicare Part B and not be eligible for any other Medicaid coverage. Income limits are from 120 percent of the Federal Poverty Level (FPL) to 135 percent of the FPL. Under QI-1, DSHS pays the client's Medicare Part B premium **only**. **This program sunsets on 12-31-02 and will cease unless Congress renews the program.**

QUALIFIED INDIVIDUAL (QI-2): The client must have applied for or be enrolled in Medicare Part A and not be eligible for any other Medicaid coverage. Income limits are from 135 percent of the Federal Poverty Level (FPL) to 175 percent FPL. Clients who are eligible for QI-2 receive help with the cost of their Medicare premium in the form of a cash payment (currently $3.91 per month) which is paid annually. Federal funding for QI-2 is limited. **This program sunsets on 12-31-02 and will cease unless Congress renews the program.**

QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI): The client must have applied for or be enrolled in Medicare Part A as a working disabled person who has exhausted premium-free Part A and whose SSA disability benefits ended because the clients earnings exceeded SSA's gainful activity limits. Income limits are based on 200 percent of the Federal Poverty Level (FPL). DSHS pays the client's Medicare Part A premium **only**.

Effective April 1, 2002:

Cost Sharing Program	Federal Poverty Level	One Person	Two Persons
QMB	100%	$ 739	$ 995
SLMB	120%	$ 886	$1,194
QI-1	135%	$ 997	$1,344
QI-2	175%	$1,293	$1,742
QDWI	200%	$1,477	$1,990
Resource Limit		$4,000	$6,000

MEDICALLY NEEDY (MN)

MEDICALLY NEEDY: MN (Medically Needy) is a federal and state funded Medicaid program for aged, blind, or disabled persons, pregnant women, children and refugees with income and/or resources above CN limits. It provides slightly less medical coverage than CN, and requires greater financial participation by the client.

Medically Needy (MN) clients with income above MN limits and Medically Indigent (MI) clients with income and/or resources above MI limits are required to spend down excess income before medical benefits can be authorized. The client spends down the excess by incurring medical bills equal to the spenddown amount. **The client is responsible for paying these medical bills.**

Effective January 1, 2002:

NUMBER OF PERSONS	MN RESOURCE LIMIT	MN INCOME LIMIT
1	$2,000	$ 571
2	$3,000	$ 592
3	$3,050	$ 667
4	$3,100	$ 742
5	$3,150	$ 858
6	$3,200	$ 975
7	$3,250	$1,125
8	$3.300	$1,242
9	$3,350	$1,358
10	$3,400	$1,483
+10	+$50/Person	Maximum $1,483

SPENDDOWN

SPENDDOWN: Spenddown is like an insurance deductible. Spenddown is the process through which excess income for MN and excess income and/or resources for MI are assigned to the client's cost of medical care. The client must incur medical expenses equal to the excess amount (spenddown) before medical benefits can be authorized.

The amount of the client's spenddown is computed using a base period, consisting of three or six consecutive calendar months. Depending on when spenddown is met, the client may get medical benefits for all or part of the base period.

SPENDDOWN EXAMPLE: Applicant is a single woman, age 67. She receives $601 Social Security benefits each month and has $1,000 in savings.

Resources: The client's $1,000 resources are below the aged resource limit of $2,000, so she is resource eligible.

Income: Her income is above MN income limits, but MN allows spenddown of excess income. She is eligible for MN when she meets spenddown.

SSA benefits	$601
General disregard*	-20
	581
Less MN income limit	-571
Excess income	$ 10

The client can choose between a three-month or a six-month base period, based on her amount of spenddown and the amount of medical bills she expects. She will have to incur either $30.00 ($10 times 3 months) or $60.00 ($10 times 6 months) medical expenses before she is eligible for MN. She will be responsible for these expenses; MAA will pay for her covered medical expenses after she meets spenddown.

*General Disregard: We allow $20 of the client's income to be disregarded when determining income limits.

GENERAL ASSISTANCE

MEDICAL CARE SERVICES (MCS): MCS is the state-funded medical program that provides limited medical benefits to persons eligible for Alcoholism and Drug Addiction and Treatment and Support Act program (ADATSA) and General Assistance-Unemployable (GA-U). Income and resource limits are the same as for CN medical programs. MCS does not cover out-of-state medical care.

GENERAL ASSISTANCE–UNEMPLOYABLE (GA-U): The GA-U is a state-funded program that provides cash and medical benefits for persons who are physically and/or mentally incapacitated and unemployable for more than 90 days. Medical care is limited.

GENERAL ASSISTANCE–EXPEDITED MEDICAID DISABILITY (GA-X): The GA-X program provides cash and medical benefits to persons who have a disability decision pending with SSA. Eligible persons receive full scope CN medical coverage.

GA-U IMMIGRANTS: Immigrants determined to meet eligibility requirements for GA-U are eligible for state-funded Medical Care Services.

GENERAL ASSISTANCE FOR ALCOHOLISM AND DRUG TREATMENT (GA-W): ADATSA is the state-funded program which provides cash and/or medical benefits, treatment, and support for persons incapacitated from gainful employment due to drug or alcohol abuse. Eligible persons receive limited medical coverage. Only medical is available to persons waiting to get into treatment. Income and resource limits are the same as for family CN medical.

MEDICALLY INDIGENT (MI)

The state-funded Medically Indigent (MI) program provides very limited medical coverage for persons with an emergency medical condition requiring hospital services who are not eligible for any other medical program. Income and resource limits for the MI program are the same as for MN. Clients with excess income and/or resources above the MI limits must spend down the excess before they are eligible for MI.

EMERGENCY MEDICAL EXPENSE REQUIREMENT (EMER): MI requires a yearly (a continuous 12-month period) EMER of $2,000 per family before they are eligible. The EMER is comparable to a deductible on an insurance policy. An applicant can meet this requirement with **emergency** medical expenses **only.**

Important: The maximum length of certification for MI is three months in any 12-month period.

An emergency medical condition is a medical condition with acute symptoms of sufficient severity (including severe pain) which could result in one of the following without immediate medical attention:

- Placing the client's health in serious jeopardy;
- Impairment to bodily functions; or
- Cause dysfunction of any bodily organ or part.

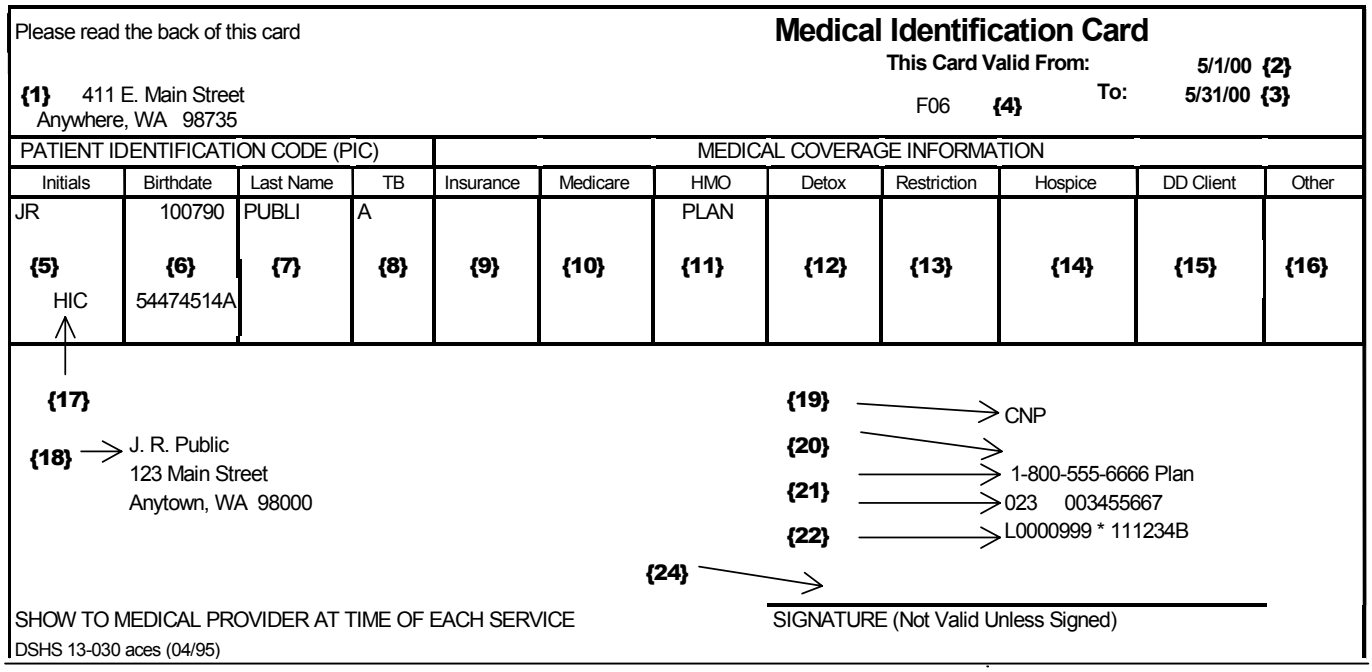
MI clients with an emergency medical condition may receive coverage for:

- Ambulance/emergency transportation to hospital or hospital emergency room;
- Emergency room services;
- Inpatient/outpatient hospital services received in hospital or hospital emergency room; and
- Physician services in the hospital or hospital emergency room.

MEDICAL ID CARD

Persons who receive medical coverage get a Medical Assistance ID card each month. Here is a sample ID card.

Sample Medical ID Card



The codes below are the medical coverage group found in field 4 on the coupon. These codes identify the type of medical assistance the patient is receiving. Identification of medical coverage group helps the provider determine if the patient may be a Healthy Options enrollee.

Medical Coverage Group Codes – Field 4	Medical Coverage Group Definitions
C01, C95, AND C99	Waivered and Community Based Programs such as CAP, COPES
D01, D02	Foster Care, Adoption Support, and Juvenile Rehabilitation Services
F01, F02, F03, F04, and F09	Family Medical
F05, F06, F08, F95, and F99	Children's Medical
F07	CHIP
GO1 and G02	General Assistance
G03, G95, and G99 facility (ALF)	Medical Assistance for a resident of Alternate Living Facility (ALF)
I01	Institution for the Mentally Diseased (IMD)
K01,K03,K95, and K99	Long Term Care – Families
L01, L02, L04, L95, and L99	Long Term Care – Aged, Blind, Disabled
M99	Medically Indigent (MI)
P02, P04, and P99	Pregnancy related
P05	Family Planning Only
R01 R02, and R03	Refugee
S01, S02, S07, S95, and S99	Aged, Blind, or Disabled (SSI) and Breast & Cervical Cancer Treatmt.
S03, S04, S05,	Medicare Savings Program
S08	Healthcare for Workers with Disabilities
WO1, W02 and W03	ADATSA

KEY TO MEDICAL ID CARD

AREA DESCRIPTION

1 Address of CSO.
2 Date eligibility begins.
3 Date eligibility ends.
4 Medical coverage group described in the table on the previous page.

Patient Identification Code (PIC) Segments Are:

5 First and middle initials *(or a dash (-) if the middle initial is not known)*.
6 Six-digit birth date, consisting of numerals only *(MMDDYY)*.
7 First five letters of the last name *(and spaces if the name is fewer than five letters)*.
8 Tie breaker *(an alpha or numeric character)*.

Medical Coverage Information

9 **Insurance carrier code** - A four-character alphanumeric code *(insurance carrier code)* in this area indicates the private insurance plan information.
10 **Medicare** - *Xs* indicate the client has Medicare coverage.
11 **HMO** *(Health Maintenance Organization)* – Alpha code indicates enrollment in an MAA Healthy Options managed health care plan. ***(Managed health care plan is the same as health maintenance organization or HMO).*** This area may also contain the legend PCCM *(primary care case manager)*. The following ACES medical coverage groups, if not otherwise exempt, are required to enroll in Healthy Options: F01, F02, F03, F04, F05, F06, F07, and P02.
12 **Detox** - *Xs* indicate eligibility for a 3-day alcohol or a 5-day drug detoxification program.
13 **Restrictions** - *Xs* indicate the client is assigned to one physician and one pharmacist. The words "client on review" in Field 20 will also indicate restricted clients.
14 **Hospice** - *Xs* indicate the client has elected hospice care.
15 **DD client** - *Xs* indicate this person is a client of the DSHS Division of Developmental Disabilities.
16 **Other** - This area is not in use.
17 **HIC** shown here indicates that the client is on Medicare.
18 **Name** and address of client, head of household or guardian.
19 **Medical program** and scope of care indicators.
20 **Other messages** *(e.g., client on review, delayed certification, emergency hospital only)*.
21 **Telephone number and name** of PCCM or Healthy Options plan.
22 **Local field office** *(3 digits)* and ACES assistance unit # *(9 digits)*.
23 **Internal control numbers** for DSHS use only.
24 **Client's signature** - May be used to verify identity of client.

COVERED SERVICES – AS OF JANUARY 2001

MAA provides a wide range of medical services. Not all eligibility groups receive all services. Coverage is broadest under the Categorically Needy (CN) program and most restricted under the Medically Indigent (MI) program.

The table below lists major services which are available to clients by program: CN (Categorically Needy), MCS (Medical Care Services for GAU and ADATSA), MN (Medically Needy), and MI (Medically Indigent).

SERVICE	CN[1]	MCS	MN	MI
Adult Day Health	Yes	Yes	No	No
Advanced RN Practitioner Services	Yes	Yes	Yes	R[2]
Ambulance/Ground and Air	Yes	Yes	Yes	R[2]
Anesthesia Services	Yes	Yes	Yes	R[2]
Audiology	Yes	Yes	HK	No
Blood/Blood Administration	Yes	Yes	Yes	R[2]
Case Management - Maternity	L	No	L	No
Chiropractic Care	HK	No	HK	No
Clinic Services	Yes	Yes	Yes	R[2]
Community Mental Health Centers	Yes	L[4]	Yes	No
Dental Services	Yes	R	Yes	No
Dentures Only	Yes	Yes	Yes	No
Detox Alcohol (3 days)	Yes	Yes	Yes	L[9]
Detox Drugs (5 days)	Yes	Yes	Yes	L[9]
Drugs and supplies, prescription	Yes	Yes	Yes	R[2]
Elective Surgery	Yes	Yes	Yes	No
Emergency Room Services	Yes[8]	Yes[8]	Yes[8]	R[2]
Emergency Surgery	Yes	Yes	Yes	R[2]
Eye Exams and Glasses	Yes	Yes	Yes	No
Family Planning Services[5]	Yes	Yes	Yes	No
Healthy Kids (EPSDT)	Yes	No	Yes	No
Hearing Aid	Yes	Yes	HK	No
Home Health Services	Yes	Yes	L	No
Hospice	Yes	No	Yes	No
Indian Health Clinics	Yes	No	Yes	No
Inpatient Hospital Care	Yes	Yes	Yes	R[2]
Involuntary Commitment	Yes	Yes	Yes	Yes
Maternity Support Services	Yes	No	Yes	No
Medical Equipment	Yes	Yes	Yes	No
Neuromuscular Centers	Yes	No	Yes	No
Nursing Facility Services	Yes	Yes	Yes	Yes
Nutrition Therapy	HK	No	HK	No
Optometry	Yes	Yes	Yes	No

SERVICE	CN[1]	MCS	MN	MI
Organ Transplants	Yes	Yes	Yes	R[2]
Orthodontia	L	No	No	No
Out-of-State Care	Yes	No	Yes	No
Outpatient Hospital Care	Yes	Yes	Yes	R[2]
Oxygen/Respiratory Therapy	Yes	Yes	Yes	R[2]
Pain Management (Chronic)	Yes	Yes	Yes	No
Personal Care Services	Yes	No	HK	No
Physical/Occupational/Speech Therapy	Yes	Yes	HK L[6]	No
Physical Medicine and Rehab	Yes	Yes	Yes	R[2]
Physician	Yes	Yes	Yes	R[2]
Podiatry	Yes	Yes	Yes	No
Private Duty Nursing	L	L	L	No
Prosthetic Devices & Mobility Aids	Yes	Yes	Yes	R[2]
Psychiatric Services	Yes	No	Yes	No
Psychological Evaluation	L	L	L	No
Rural Health Services & FQHC	Yes	Yes	Yes	No
School Medical Services[3]	Yes	No	Yes	No
Substance Abuse/Outpatient	Yes	No[7]	Yes	No
Total Enteral/Parenteral Nutrition	Yes	Yes	Yes	No
Transportation Other Than Ambulance	Yes	Yes	Yes	No
X-Ray and Lab Services	Yes	Yes	Yes	R[2]

KEY: **Yes** Service is covered (may require prior approval or have other requirements). **No** Service is not covered.

HK Coverage limited to Healthy Kids program only (health checkup and treatment program for children under 21)

L Limited coverage

R Restricted to emergency medical conditions.

1 Includes all CN programs, the state-funded Children's Health (V) program and services available to undocumented alien pregnant women.

2 Only covered if an emergency medical condition requiring in-hospital services.

3 A program for Medicaid children in school Special Education Programs.

4 Clients must meet the priorities and definitions of the Community Mental Health Act. Limited grants to counties fund these services.

5 All clients covered under all medical care programs receive family planning services. Women eligible for medical care during pregnancy receive family planning services only up to 12 months after pregnancy ends.

6 When the client is receiving home health care services.

7 Paid for out of ADATSA funds.

8 A $3.00 copay will be charged to non-pregnant adults who use the emergency room for services that are not related to an emergency medical condition. AI/AN are exempt from paying a copayment.

9 In hospital emergency detox only.

Customer Toll-Free Numbers

Medical Assistance Customer Service Center (Clients) 1-800-562-3022
7am-7pm, Monday-Friday
TTY/TDD users only 1-800-848-5429

Medical eligibility Determination Services (MEDS) 1-800-204-6429
TTY/TDD users only 1-800-204-6430

Pharmacy Authorization 1-800-848-2842

Provider Enrollment 1-866-545-0544
8am-4:30pm, Monday–Friday, 10am-4:30pm Wednesday

Provider Inquiry 1-800-562-6188

Third Party Resource Hotline (Coordination of Benefits) 1-800-562-6136

Basic Health Plan 1-800-826-2444

Useful Web Addresses

DSHS Rules - (Washington Administrative Code)	http://www.wa.gov/dshs/dockets/wacidx.html
Economic Services Administration (to locate your CSO, applying for assistance including medical on line, etc)	https://wws2.wa.gov/dshs/onlinecso/
Eligibility A-Z Manual	http://www.wa.gov/dshs/eazmanual/default.htm
MAA Internet	https://wws2.dshs.wa.gov/maa/eligibility
MAA Intranet	http://maaintra.dshs.wa.gov
MAA Billing Instructions	https://wws2.wa.gov/dshs/maa/download/downloadbilling.html
MAA Numbered Memos	https://wws2.wa.gov/dshs/maa/downlaod/downloadmemos.html
Washington State Law (RCWs)	http://www/leg/wa/gov/wsladm/rcw.htm
Basic Health Plan	http://www.wa.gov/hca/basichealth.htm

Useful Web Addresses

DSHS Rules .....http://www.wa.gov/dshs/dockets/wacidx.html
(Washington Administrative Code)

Economic Services
Administration https://wws2.wa.gov/dshs/onlinecso
For locating your CSO, applying for assistance including medical on line, etc

Eligibility A-Z Manual http://www-app2.wa.gov/dshs/EAZManual/

MAA Internet.....https://wws2.dshs.wa.gov/maa/eligibility

MAA Intranet.....http://maaintra.dshs.wa.gov

Washington State Law .....http://www/leg/wa/gov/wsladm/rcw.htm
(RCWs)

Basic Health Plan.....http://www.wa.giv/hca/basichealth.htm